DEPARTMENT OF DEVELOPMENTAL SERVICES
NURSING HEALTH AND SAFETY ASSESSMENT

Name: DDS#: DOB:

Address: Phone:

Evaluating RN: Date completed: Revision dates:

Source of information (indicate all that apply)	Reason for Assessment
☐ Individual	☐ Baseline Assessment
☐ Records	☐ Program/Services Prescreening
☐ Family Member:	☐ Clinical Referral
☐ Case Manager:	☐ Discharge ☐ Change of condition
☐ Provider:	☐ Other:

Living Situation	☐ Supported Living ☐ CRS	
☐ Community Companion Home	☐ Family Home	☐ Own home
☐ Community Living Arrangement	☐ ICF/MR	☐ Other (specify)

Legal Status: ☐ **Non-adjudicated** ☐ **Plenary guardian** ☐ **Limited medical guardian** ☐ **Conservator**

Contact Person:
Name: Relationship:
Address:
Phone: E-Mail:
☐ **Emergency Contact** ☐ **Guardian** ☐ **Other:**
Name: Relationship:
Address:
Phone: E-Mail:

Employer/Day Program/School:
Contact person: Phone:

Insurance Information:
☐ Medicaid (Title XIX) Number:
☐ Medicare Number:
☐ Private Company:
Number: Subscriber:
☐ Medicare D Carrier: Number:

II: <u>Current Medical Information</u>:

Communication: ☐ Verbal ☐ Sign ☐ Written ☐ Assistive technology ☐ Non-verbal
☐ Other Primary Language:

Ambulation Status: ☐ Independent ☐ Assist ☐ Adaptive device:

Fall Risk: ☐ Yes ☐ No ☐ Check here if assessment attached

Diagnoses:

Advance Directives/DNR: ☐ None

Seizure Disorder: ☐ NA ☐ Type: Frequency: ☐ VNS

History of Illnesses/Injuries/Hospitalizations (recent)**:**

Family Health Issues:

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☐ Family Health History Form attached ☐ Records Incomplete/unknown
☐ Other:

Allergies: ☐ Epipen

Current Medications: (attached additional pages as needed)

Drug	Dose	Route	Time/Freq.	Date Started	Reason for Use

Medication concerns: (include dependency/addiction and compliance concerns, new medications in last 3 months):

Self medication assessment completed: ☐ Yes ☐ No ☐ Check here if attached

How medication administered:

Adaptive/medical equipment: ☐ Glasses ☐ Dentures ☐ Hearing Aids ☐ Other:

Bed Side Rails ☐ Yes ☐ No Specify type and frequency:

Adaptive Bed ☐ Yes ☐ No Specify:

Immunizations: ☐ Records incomplete/status unknown

Type	Date Given	Type	Date Given
Tetanus/diphtheria		Pertussis	
Pneumovax		Influenza	
Measles (Rubeola)		Rubella	
Polio		Mumps	
Hepatitis B*	If no Hep B vaccination list status:		
Tuberculosis (PPD)		Other:	
Other:		Record requested date:	

Diet: ☐ Regular (no restrictions)
☐ Therapeutic Diet (low cholesterol, low fat, no added salt, etc.) Specify:
☐ Enteral feeding (specify type, product and frequency):

Food and Liquid consistency: ☐ Whole (no alterations) ☐ Cut-Up (1/2x1/2x1/2) ☐ Chopped (1/4x1/4x1/4)
☐ Ground ☐ Pureed ☐ Mixed (specify):
☐ Thin liquids (non-restrictive) ☐ Nectar ☐ Honey ☐ Pudding

Consistency considerations for medications:

Other information/concerns about nutritional status, eating habits, weight, support needs:

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Swallowing Risks: (specify all that apply)

Eating: ☐ Rapid eating ☐ Gorging/stuffing food ☐ Recurrent refusal of food/liquids/meds
☐ Loss of food/liquid from mouth while eating ☐ Motor/sensory concerns
Chewing: ☐ Difficulty chewing ☐ Absent/no chewing ☐ No teeth or few teeth
Swallowing: ☐ Choking ☐ Coughing during or after meals ☐ Gagging on food/liquid
☐ Difficulty swallowing ☐ Excessive throat clearing when eating or drinking

Behavior: ☐ Agitation ☐Lethargy ☐ Inattention ☐ Distractibility ☐ Vocalizations during meals
☐ PICA ☐ Other (specify):
☐ None of the risks specified above have been observed/reported for this individual.
☐ Dining guidelines: ☐ Yes ☐ No ☐ Check here if attached

Current Health Care Providers:
Primary: Phone:
Address: Last seen:
Others: Include Dentist, Neurologist, Psychiatrist, Psychologist, Podiatrist, etc. (specify name, address, phone, and date last seen and frequency of review/follow-up visits).

Health Specialty	Address	Phone	Date Last Seen	F/U Visit
Primary				
Dental				
Vision				
Pharmacy				
VNA				
Other				

III. Vital Baseline or Receiving Nurse Assessment

Vital Signs

Date: B/P: T: P: R:
Ht: Wt: Ideal Body Weight/BMI: ☐ Not determined

IV. Health Skills Assessment

Requires assistance to understand medical treatments (if "yes" specify all who assist): ☐ Yes ☐ No
☐ Staff ☐ Nurse ☐ Family ☐ Guardian ☐ PCP ☐ Other:
Attends medical appointments independently (if "no" specify type of assistance needed): ☐ Yes ☐ No
☐ Transportation ☐ Staff to accompany ☐ Other:

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IV. ADL Skills: (Specify level of assistance needed)

	Independent	Needs Prompts	Needs Supervision	Needs Physical Assistance	Needs Total Assistance
Bathing					
Grooming					
Shaving					
Dressing					
Eating					
Tooth brushing					
Toileting					
Ambulating					
Transfers					
Meal prep					
Shopping					
Other					

V. Recommended Health Follow-Up

Conditions to be Monitored	Follow Up Needed	Appointments Due/Scheduled

Signature of RN Completing Assessment | Date | Region/Agency

If this form is used for the transfer of information, complete below and retain copy at previous placement

Signature of Receiving RN | Date | Region/Agency

Distribution: Individual's file, Evaluating RN, Case Manager

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